ALABAMA BOARD OF ADJUSTMENT
CLAIM FOR PERSONAL INJURY/PROPERTY DAMAGE

Print Form

Instructions: USE THIS FORM TO CLAIM DAMAGES FOR PERSONAL OR PROPERTY DAMAGE OR BOTH. READ THE ENTIRE CLAIM FORM FOR DETAILED INSTRUCTIONS.

THIS CLAIM MUST BE SIGNED AND THE INFORMATION THAT YOU PROVIDE VERIFIED AS TRUTHFUL UNDER OATH BEFORE A NOTARY PUBLIC.

THE DEADLINE FOR FILING A CLAIM:
A CLAIM MUST BE FILED WITH THE BOARD OF ADJUSTMENT WITHIN ONE YEAR OF THE DATE ON WHICH THE INJURY OR DAMAGE OCCURRED.

The burden of proving that payment is due rests with the claimant. Give complete information and attach all documentation to prove your claim including the documents specified in this form. Failure to provide complete information with this claim may affect the decision of the Board.

DO NOT WRITE IN THIS SPACE

Claim No.: Supplement No.:

If a SUPPLEMENT to a previously filed claim, provide original Claim Number:

FILE THIS FORM AND ALL DOCUMENTS BY MAILING TO:
State Board of Adjustment
600 Dexter Avenue, Suite E-302
Montgomery, AL 36130-1435

OR DELIVER TO: State Board of Adjustment
State Capitol Building, Suite E-310
Montgomery, AL

Name of Department or Agency of the State of Alabama against which you are making this claim:

NOTICE: ALL COMMUNICATIONS WITH THE CLAIMANT REGARDING THIS CLAIM WILL BE BY FAX OR E-MAIL TO THE FAX NUMBER OR E-MAIL ADDRESS SHOWN IN ITEM A.1., UNLESS THIS BOX IS MARKED. ☐ AFTER FILING THIS ORIGINAL CLAIM FORM, SIGNED AND NOTARIZED WITH SUPPORTING DOCUMENTATION, CLAIMANT MAY COMMUNICATE WITH THE BOARD OF ADJUSTMENT BY E-MAIL AT BOADJ@FINANCE.ALABAMA.GOV. THE CLAIM NUMBER MUST BE STATED IN THE SUBJECT LINE.

A. Claimant Information:

1. Name and Mailing Address of Claimant for communications regarding this claim:

Claimant:

To Attention of:

Mailing Address:

(Street or Post Office Box) *(City)* *(State)* *(Zip Code)*

Social Security No. for individual claimant or Federal ID No. for business claimant *[required for issuance of State check]*:

If injured party is a minor (under 19 years of age), CLAIM MUST BE SIGNED AND FILED BY PARENT OR GUARDIAN AS CLAIMANT. Give name and age of minor and the name and relationship of person with whom minor lives.

Home Telephone Number: Other(Cellular/ Work)

Fax Number: E-mail Address:

2. Claimant's Attorney (*If an attorney is representing claimant on this claim, all correspondence and communication will be with that attorney*):

Name:

Mailing Address:

(Street or Post Office Box) *(City)* *(State)* *(Zip Code)*

Telephone Number: Fax Number:

E-mail Address:

B. Facts of Claim:

1. Date of accident of injury:

2. Where did the accident or injury occur:

3. Statement of Facts: **Describe how your injury or the damage occurred. Attach a copy of any official accident or incident report and other documents which prove your right to be paid and show the type and amount of your damages. Attach additional pages if necessary.**

[Claimant Name]

C. Damages to Personal Property:

1. Amount Claimed: **Attach bills, receipts, etc. to substantiate amount claimed. If automobile, attach two estimates of repair costs.**

2. Describe Property (year/make/model of vehicle, watch, eyeglasses, clothing, etc.:

3. Do you have insurance which would cover all or part of the damage? Yes ☐ No ☐
   If yes, give name of insurance company:

4. Amount of coverage: Deductible: (Attach copy of Declaration Page indicating which types and amount of coverage.)

5. Have you filed for coverage to which you are entitled under your policy? Yes ☐ No ☐

D. Personal Injury:

1. Describe the personal injury you suffered *[Attach additional pages if necessary. Provide a report from your doctor that describes your injuries and treatment]:*

2. List each health care provider (including pharmacy) and the amount charged by each:

3. *ALL EXPENSES MUST FIRST BE SUBMITTED TO YOUR INSURANCE COMPANY FOR ANY AVAILABLE COVERAGE. ATTACH DOCUMENTATION TO SUBSTANTIATE AMOUNT CLAIMED, SUCH AS ITEMIZED BILLS AND INSURANCE COMPANY STATEMENTS SHOWING THE EXPENSES PAID OR PAYABLE BY INSURANCE. ADDITIONAL PAGES IF NEEDED.*
   If you had insurance for your damages at the time of the accident, name all insurance companies and state how much each paid you:

4. On-the-job Injury:
   a) If this injury was incurred while you were on-the-job, give the name and address of your employer:

   b) If this was an on-the-job injury, give the dates you were out of work and the amount of compensation you were paid *[Attach documentation to substantiate the compensation you were paid]:*

5. What is the total amount you are claiming for the personal injury expenses claimed in this section (D):

E. Permanent Disability:

1. Are you claiming damages for permanent disability? Yes ☐ No ☐
2. Have you claimed compensation for permanent disability for this injury from any other source, such as Social Security Disability, Workers Compensation, etc.? *(Attach documents indicating the amount received from other sources.)* Yes ☐ No ☐
3. What is the amount you are claiming from the State to compensate you for permanent disability?
4. Describe the permanent disability *[Attach detailed statements by a doctor or vocational expert describing extent of disability. Attach additional pages if necessary.]*

5. Rate of pay at time of injury: per Hour ☐ Day ☐ Week ☐ Month ☐

F. If you are claiming lost wages and/or compensation for leave used, list each separately. *[Attach doctors excuse for dates missed from work. Attach verification of dates and rate of pay from employer]* :

1. Amount of lost wages: _____ for _____ hours/days/weeks/etc.

2. Amount of leave used: _____ for _____ hours/days/weeks/etc.

3. Period (dates) for which claim is made: _____

4. Rate of pay at time of injury: _____ per Hour ☐ Day ☐ Week ☐ Month ☐

G. List other expenses you are claiming and the amount for each. *[Attach documentation to substantiate. Attach additional pages if necessary.]*:

Item	Amount of Expense

H. What is the TOTAL AMOUNT you are claiming for all items described in Sections C.1., D.5., E.3., F.1., F.2. above: _____

[This amount must be stated]

I. Assignment:

I represent that no part of this claim has been assigned to another entity and no amount has been paid to me or on my behalf or received by me in payment for any damages/injury complained of herein except as set out as follows: *[List amounts you have not described in previous sections.]*

Signature of claimant/authorized representative: _____

Please print name: _____

VERIFICATION

STATE OF _____)

COUNTY OF _____)

Before me, a Notary Public in and for said state and county, personally appeared the person whose name is signed above who being made known to me and being duly sworn to give true testimony, affirmed that all of the above stated facts are true and correct.

Sworn and subscribed before me this _____ day of _____, 20 _____

AFFIX SEAL

Signature of Notary Public _____

Printed Name _____